KANSAS
DEPARTMENT OF LABOR
Division of Workers Compensation

DATE:_____

TO: DIVISION OF WORKERS COMPENSATION
DEPARTMENT OF LABOR
800 SW JACKSON STE 600
TOPEKA KS 66612-1227
e-mail address – wcselfinsurance@dol.ks.gov

CERTIFICATE OF EXCESS INSURANCE

This certifies that a Workers Compensation Excess Insurance Policy has been issued and delivered to the employer named below, and that by issuance and delivery of said policy and the filing of this certificate of insurance, it is admitted that said excess policy was effective on the date stated below and that the coverage provided therein is applicable to benefits under the Workers Compensation Act of the state of Kansas and that said policy shall remain in full force and effect until 20 days after receipt by the Division of Workers Compensation of notice of its cancellation or expiration and/or non-renewal.

Name of Employer Insured:_____

Address:_____

Name of Insurer:_____

Address:_____

Policy Number:_____ Effective Date:_____

Expiration Date:_____

FORM OF COVERAGE

*Specific Excess

Policy Limit: STATUTORY
(Per occurrence)

Specific Retention: $_____
(Per occurrence)

Policy Term: _____

*Aggregate Excess

Policy Limit: $_____

Loss Fund Percentage:_____

Minimum Loss Fund: $_____

Estimated Loss Fund: $_____

Policy Term: _____

If more than one insurer is providing coverage, you must provide separate certificates for each insurer.

***No changes shall be made to the Self-insured Specific Retention Amount or other limits of the policy upon renewal until approval is granted by the Division of Workers Compensation.**

_____
Insurer

_____
Authorized Representative Signature

_____
Address